



**BlueCross  
BlueShield**

Federal Employee Program

## DICLOFENAC SODIUM GEL/SOLUTION

### PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the provider portion and submit this completed form.

Send completed form to:  
Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn: Clinical Services  
Fax: **1-877-378-4727**

Patient Information (required)				Provider Information (required)			
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:	Zip:	City:		State:	Zip:
Patient ID: <b>R</b>				Physician Signature:			
<b>PHYSICIAN COMPLETES</b>							

## Diclofenac Sodium Gel/Solution

**NOTE:** Form must be completed in its **entirety** for processing

### Please select medication:

☐ Diclofenac sodium gel 1% (Voltaren)

☐ Diclofenac sodium topical solution 1.5% (Pennsaid)

☐ Diclofenac sodium topical solution 2% (Pennsaid)

\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit

\*\*Non-covered branded medications must go through prior authorization and the formulary exception process

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

☐ Osteoarthritis (OA)

☐ Pain

☐ Other diagnosis (*please specify*): \_\_\_\_\_

2. **Diclofenac Sodium Gel 1% Request**, please answer the following question:

a. How many grams will the patient need for a 90 day supply? \_\_\_\_\_ gram(s) per 90 days

3. **Diclofenac Sodium Topical Solution 1.5% or 2% Request**, please answer the following questions:

a. Does the patient have osteoarthritis of the knee(s)? ☐ Yes ☐ No

b. How many bottles will the patient need for a 90 day supply? \_\_\_\_\_ bottle(s) per 90 days



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<b>Electronically Online</b> (ePA) <b>Results in 2-3 minutes</b> <b>FASTEST AND EASIEST</b>	Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to <b>Caremark.com/ePA</b> .
<b>Phone</b> (4-5 minutes for response)	The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
<b>Fax</b> (3-5 days for response)	Fax the attached form to <b>(877)-378-4727</b> . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>

<b>faster... easier... better...</b>	Introducing ePA! Online Prior Authorizations in minutes through <b>Caremark.com/ePA</b> . Sign up today!
	<b>CVS/caremark</b> 